AUTHORIZATION FOR USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

to an Authorized Individual/Personal Representative

I, _____, Policy/Certificate ID _____ hereby authorize the use and disclosure of my protected health information for: coverage administration, billing information and/or claims information, or as defined, or limited to the following:

_____

_____

The Mutual of Omaha Insurance Company may release my protected health information as described above to the following person(s):

_____

Printed Name of Authorized Individual(s) Phone Number

_____

Street Address

_____

City State Zip Code

This form is for use and disclosure of information only; it does not authorize anyone other than me or my legal representative to make any changes to my coverage, billing or demographic information. I understand that if the person or entity that receives my information is not covered by federal privacy regulations, my information may be re-disclosed by such person or entity, and will then no longer be protected.

This authorization is valid until my coverage ends, unless a specific expiration date or event is specified here: _____. I understand that I may revoke this authorization in writing at any time. I am entitled to make a copy of, or request to receive a copy of this authorization.

I understand that I am not required to sign this authorization and that benefits or eligibility will not be conditioned upon my choice not to sign. I further understand that my protected health information cannot be disclosed to any unauthorized third party without my signature.

I acknowledge by my signature below that I have read and understand this Authorization. It accurately reflects my wishes, and a photocopy, facsimile, or other electronic copy is as valid as the signed original.

_____

Signature of Policy/Certholder or *Legal Representative Date

*If you are signing as a legal representative, describe the scope of your authority to act on their behalf and include a copy of the documentation of your legal authority.